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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

MICHAEL E. GRANBERRY, M.D.

Holder of License No. **28676**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-06-0079A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 8, 2007. Michael E. Granberry, M.D., ("Respondent") appeared before the Board with legal counsel Michael D. Wolver for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 28676 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0079A after receiving a complaint regarding Respondent's care and treatment of a sixty-six year-old female patient ("EA") alleging Respondent failed to treat infectious complications of LASIK surgery in a timely manner leading to loss of vision in EA's right eye. EA presented to Respondent's practice on April 28, 2005 and was seen by an optometrist ("Optometrist") who noted moderate myopia and cataracts in both eyes and counseled EA to have mono-vision laser correction. Respondent performed this procedure on May 6, 2005 and saw EA one day post-op and noted she was doing well.

1 4. EA called Respondent's office the morning of May 8 complaining of severe pain
2 and decreased vision in her right eye. Respondent saw EA and elevated her flap and washed out
3 the bed. Respondent did not take a culture. Respondent placed a bandage contact lens. The
4 following day EA saw Optometrist who increased EA's prednisone drops to every hour. On May
5 10 EA again saw Optometrist who diagnosed diffuse lamellar keratitis, removed the contact lens,
6 and added additional antibiotic drops. Optometrist saw EA again on May 19 and noted increasing
7 infiltrate under the flap and suggested EA see Respondent. Respondent performed a second flap
8 lift that day and placed a bandage contact lens, again without taking cultures. Optometrist saw EA
9 for the next two visits and noted continual worsening of her condition. Respondent was notified,
10 but was not available to see EA until three days later when there was a profound worsening of
11 EA's condition. Respondent then referred EA to a corneal specialist.

12 5. The specialist, noting there was complete loss of the LASIK flap and total sloughing
13 of the corneal epithelium, obtained bacterial cultures and performed a suture tarsorrhaphy to
14 promote EA's healing. The specialist saw EA multiple times over the next several weeks and felt
15 the ulcer had become neurotrophic and he debrided the cornea again for culture. EA's epithelium
16 did not heal over until June 22, 2005. At this time she had vision of counting fingers and had
17 developed a dense stromal scar and permanent dilation of the pupil.

18 6. Respondent did not see or examine EA prior to the day of her surgery. Respondent
19 saw her two days after the original surgery and his findings were inflammation under the flap, with
20 a particular area that was denser than normal. Respondent was unsure whether it was an
21 infiltrate. To rule out whether or not there is an infiltrate a culture can be taken or it can be treated
22 empirically. Even though an infiltrate was part of his differential diagnosis, Respondent did not
23 take a culture because he believed the antibiotics he had given EA were the best treatment and
24 the culture was not necessary and, even if he had taken one, would not have changed the
25 treatment unless it came back resistant to the antibiotic EA was already on. Respondent does not

1 culture all inflammation, and diffuse lamellar keratitis is much more common and the treatment for
2 it is an increase in steroids.

3 7. Respondent disagreed that when he saw EA eleven days after the May 11th visit
4 she was not improved. Respondent did not do a culture because EA was improved – her vision
5 was improved, there were essentially no symptoms, she was responding to the therapy – and he
6 increased the antibiotics. When Respondent saw EA on the 24th she had gotten worse and he
7 referred her out to the specialist who had the equipment and staff to deal with the infection.
8 Respondent believed EA had a trauma to the eye after the 19th that caused more inflammation,
9 yet he still did not perform a culture to rule out an infiltrate. Respondent admitted EA's infection
10 could have been resistant to the antibiotic and his increasing the steroids could have exacerbated
11 the infection.

12 8. Respondent uses the antibiotic Zymar prophylactically in all his patients, unless
13 they are allergic to it, to cover Staph aureus strep. The organism that was eventually cultured
14 from EA that was resistant to Zymar was a methicillin-resistant Staph aureus ("MRSA").
15 Prednisone in the face of potential infection aggravates or exacerbates infection. Whenever
16 Respondent sees white blood cells in the cornea, infection is always on his differential. For
17 instance, if he sees little infiltrates with contact lenses, it is not uncommon, but he does not
18 culture infiltrates and normally treats empirically with steroids. If Respondent was leaning more
19 toward there being inflammation, he would not treat with steroids. If he were leaning toward
20 inflammation, but thought there was a possibility of infection, Respondent would continue the
21 antibiotic.

22 9. Respondent re-elevated the flap on May 8, but did not personally see EA until
23 eleven days later. Respondent did not believe he needed to see EA sooner and pay closer
24 attention to her complication and ensure the irrigation was effective because Optometrist was
25 very qualified to do this. Respondent has only seen one infection of the type EA had in 60,000

1 cases. If Respondent knew EA had an MSRA infection he would have stopped the steroids,
2 increased the antibiotic, and referred her out.

3 10. Respondent practices in Phoenix and Los Angeles doing exclusively laser vision
4 correction one or two days per week. Respondent sees patients post-operatively if Optometrist
5 asks him to. Respondent does not have a set way of following patients, other than Optometrist.
6 Ninety-nine percent of the time Respondent does bilateral procedures and does approximately 40
7 eyes each day of surgery. After medical school Respondent did a year of residency in radiology,
8 then a one year general surgery internship, and then three years of residency in ophthalmology.
9 Respondent did not do any specialty training or fellowship in refractive surgery.

10 11. Respondent sees all his patients for the first time on the day of surgery and talks to
11 them either individually or as a group. Respondent spends approximately two or three minutes
12 with the patients before he actually starts the procedures. All of the pre-operative examinations
13 are typically done by Optometrist and Respondent relies on Optometrist's physical examination
14 and findings before he does a procedure. If Optometrist misses a co-morbidity or infection,
15 Respondent will not be aware of either. Before he meets the patient Respondent looks at the
16 chart, makes sure the refraction makes sense, makes sure he is happy with the examination
17 done by Optometrist and makes sure the patient is a candidate. Respondent acknowledged he
18 determines some patients do not need the procedure and he does not proceed. Respondent does
19 not believe Optometrist was wrong in these cases and he classified these instances as "judgment
20 calls" where he may not want to do the surgery because of corneal thickness, etc. Respondent
21 reviews the patient charts either the night before or the morning of the surgeries. Because of EA's
22 case Respondent is much more likely to either culture the patient or refer out a patient he
23 suspects is going to have an infection.

12. In a post-operative LASIK patient with early onset of infiltrates under the flap the condition should be considered an infection until proven otherwise. The standard of care is to obtain bacterial cultures and commence antibiotic therapy pending outcome of the cultures.

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| 13. | Respondent deviated from the standard of care because he did not obtain bacterial cultures. | | |
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| 14. The standard of care required | Respondent to personally follow-up EA's post-operative complication. |
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| 15. Respondent deviated from the standard of care by abdicating EA's care to Optometrist. | | |
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16. EA's infection persisted and she now has a dense corneal scar with distortion of the corneal surface and will need a corneal transplant to restore vision.

CONCLUSIONS OF LAW

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| 1. | The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent. | |
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| 2. | The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action. | |
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3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failing to take a culture and failing to personally follow-up on a post-operative complication.

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Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATE 11/11/11 th C

ARIZONA MEDICAL BOARD

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STATE OF ARIZONA

By Lot Mr
TIMOTHY C. MILLER, J.D.
Executive Director

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